

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/09/2011  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>15E682</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01</b><br>B. WING _____                               |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>03/04/2011</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>INDIANA VETERANS HOME</b> |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>3851 N RIVER RD</b><br><b>WEST LAFAYETTE, IN 47906</b> |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   |  |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE |
| {K 000}  | <p><b>INITIAL COMMENTS</b></p> <p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 01/07/11 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 03/04/11</p> <p>Facility Number: 001134<br/>Provider Number: 15E682<br/>AIM Number: 200817200</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this PSR survey, Indiana Veterans Home was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2</p> <p>This facility was located in three buildings determined to be of Type I (443) construction identified as Mitchell Hall (3 story), Pyle Hall (3 story) and MacArthur Hall (4 story). The buildings were surveyed as one since they were all constructed prior to March 1, 2003. The buildings were fully sprinklered. MacArthur and Pyle Halls have basements. There is a partial basement under the mechanical room on Mitchell Hall. The facility has a fire alarm system with smoke detectors throughout the facility. The facility has the capacity for 228 and a census of 177 residents.</p> |  |  | {K 000}  |  |  |                            |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/09/2011  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |  |  |  |  |                            |
|--|---|--|--|--|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>15E682</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01</b><br>B. WING _____                               |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>03/04/2011</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>INDIANA VETERANS HOME</b> |   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>3851 N RIVER RD</b><br><b>WEST LAFAYETTE, IN 47906</b> |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)    |  |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE |
| {K 000}  | Continued From page 1<br>Quality Review by Robert Booher, REHS, Life<br>Safety Code Specialist-Medical Surveyor on<br>03/08/11. |  |  | {K 000}  |  |  |                            |